WMCP 98-32

CONFERENCE COMPARISON OF H.R. 3755

SOCIAL SECURITY DISABILITY AMENDMENTS OF 1984

Prepared for the use of the conferees

35-345 O

U.S. GOVERNMENT PRINTING OFFICE: 1984

H782-35

CONFERENCE COMPARISON OF H.R. 3755 AS PASSED BY THE HOUSE AND SENATE

Item	Present Law
1. Standard of Review for Termination of Disability Benefits (Section 101 of the House bill and Section 2 of the Senate amendment)	To be eligible for disability benefits, a person must be unable, by reason of a medically determinable impairment expected to last at least 12 months or to end in death, to perform any substantial gainful activity (SGA) that exists in the national economy, considering his or her age, education and work experience. The impairment must be "demonstrable by medically acceptable clinical and laboratory diagnostic techniques." This definition applies both to new applicants and to beneficiaries whose eligibility is being reviewed. No other statutory standards exist for the review of beneficiaries.

House Bill	Senate Amendment
Establishes a standard for reviewing eligibility of disability beneficiaries that allows benefits to be terminated only if there is substantial evidence that the beneficiary can perform SGA as a result of (a) medical improvement in his disabling condition, or (b) medical or vocational therapy technological or advances, as shown by new medical evidence and new assessment of residual functional capacity, or (c) vocational therapy or (d) a less disabling impairment than originally thought, as shown by new or improved diagnostic techniques or evaluations.	Benefits may be terminated if beneficiary can perform SGA unless the Secretary finds there has been no medical improvement. If the evidence establishes that there has been no medical improvement (other than improvement which is not related to his ability to work), benefits may be terminated only if Secretary can show (a) beneficiary has benefited from medical or vocational therapy or technology, (b) new or improved diagnostic or evaluative techniques indicate impairment(s) is not as disabling as believed at time of last decision, (c) a prior determination was fraudulently obtained, or (d) there is demonstrated substantial reason to believe a prior determination of eligibility was erroneous.
Benefits could also be terminated if evidence on the record at the time of the earlier determination or new evidence shows that the prior determination was either clearly erroneous or fraudulently obtained, or that the beneficiary is performing SGA.	Benefits may be terminated for performance of SGA or if the individual fails, without good cause, to cooperate in the review or follow prescribed treatment, or cannot be located.
In cases where there is no evidence to support the prior decision (i.e. a lost file) the Secretary would not be precluded from securing additional medical reports in order to reconstruct that decision.	In making determination, Secretary shall consider the evidence in the file as well as any additional information concerning claimant's current or prior condition secured by Secretary or provided by claimant.
	In the case of a finding relating to medical improvement, provides that burden of proof is on claimant. In other words, for benefits to be continued on this basis, individual must state and evidence in file must show that medical condition is same as or worse than at time of last decision (or, if there is medical improvement, it is not related to work ability).
Title XVI is amended to provide that the same standard of review shall apply to SSI recipients (except that the exclusions which allow termination as the result of medical or vocational therapy (described in (b) and (c) above) do not apply to individuals receiving section 1619 special benefits).	Title XVI is amended to provide that the same procedures shall apply to SSI recipients (except that the provision requiring termination on the grounds that an individual is engaging in SGA does not apply to recipients of section 1619 special benefits).
No provisions for date of implementing regulations or expiration.	Implementing regulations must be issued within 6 months of enactment. Provision expires December 31, 1987.

Item	Present Law
1. Standard of Review for Termination of Disability Benefits—Con.	

House Bill	Senate Amendment
Effective date: Applies to all cases involving disability determinations pending in the Department or in Court on the date of enactment or initiated on or after that date.	***Effective date:*** Applies to disability reviews initiated on or after date of enactment, to all individuals with claims properly pending in the administrative appeals process as of enactment, and to certain court cases. All individual litigants and named members of a class action who have cases properly pending in court as of May 16, 1984, and all individuals who properly request court review of a decision of the Secretary made during the period from March 15, 1984 until 60 days after enactment, would be remanded to the Secretary for redetermination under the new standard. Also the case of any individual who exhausted the administrative appeals process, was an unnamed member of a properly pending class action certified prior to May 16, 1984, and had been notified of the Secretary's final decision on or after a date 60 days prior to the filing of the court action, would be remanded to the Secretary. The Secretary would notify the individual that he had 60 days to request review of his claim under the new standard. If the individual did not request review, the provision would not apply and the Secretary's determination would not be subject to further administrative or judicial review. The provision would not apply to any case for which the Secretary made a final determination prior to May 16, 1984, and which was not included in the above categories. Such determination would not be subject to further administrative or judicial review. Applies the provision authorizing payments pending appeal (See item 6) to any individual whose case is remanded by a court under this section and if applicable, who timely requested redetermination. These interim payments would begin with the payment for the month in which the individual elects continued payments. If the individual is ultimately found eligible, full retroactive benefits would be provided. If he is found ineligible, the interim payments would be subject to recovery as overpayments.

Item	Present Law
2. Evaluation of Pain (Section 102 of the House bill and section 9 of the Senate amendment)	There is no statutory provision concerning the evaluation of pain (or the use of subjective allegations of pain) in determining eligibility for disability benefits. The definition of disability requires that the person be unable to work by reason of a "medically determinable impairment"—one which results from "anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." By regulation, subjective allegations of symptoms of impairments, such as pain, cannot alone be evidence of disability. There must be medical signs or other findings which show there is a medical condition that could be reasonably expected to produce those symptoms and that is severe enough to be disabling.
3. Multiple Impairments (Section 103 of the House bill and section 8 of the Senate amendment)	There is no statutory provision concerning the consideration of the combined effects of a number of different impairments. The definition of disability requires a finding of a medically determinable impairment of sufficient severity to prevent the person from doing not only his previous work but also any other kind of work that exists in the national economy, considering his age, education and work experience. By regulation, the combined effects of unrelated impairments are considered only if all are severe (and expected to last 12 months). As elaborated in rulings, "inasmuch as a nonsevere impairment is one which does not significantly limit basic work-related functions, neither will a combination of two or more such impairments significantly restrict the basic work-related functions needed to do most jobs."

House Bill	Senate Amendment
Requires the Secretary to conduct a study in conjunction with the National Academy of Sciences on the use of subjective evidence of pain in making disability determinations, and on the state of the art of preventing, reducing or coping with pain. A report on the study is due to the Committees on Ways and Means and Finance no later than April 1, 1985.	Requires Secretary to appoint 12-member commission consisting of a significant number of medical professionals involved in the study of pain, and representatives from the fields of law, administration of disability insurance programs, and other appropriate fields of expertise to study the use of pain in evaluation of disability. Report due to Committees on Ways and Means and Finance no later than December 31, 1986.
No provision.	Includes in statute the present regulatory policy on the use of evidence of pain in evaluation of disability. Includes title XVI conforming amendment. ***Effective date:*** Statutory provision applies to determinations made prior to January 1, 1988.
Requires the Secretary, in making a determination of whether a person's impairments are of such severity that he or she is unable to engage in substantial gainful activity, to consider the combined effects of all of a person's impairments, regardless of whether any impairment by itself is of such severity. Includes title XVI conforming amendment.	Same, except clarifies that the requirement applies to the determination of whether the individual has a combination of impairments which are *medically* severe without regard to age, education, or work experience. Includes title XVI conforming amendment.
Effective date: Applies to all determinations pending in the Department or in Court on the date of enactment, or initiated after that date.	***Effective date:*** Applies to all determinations made on or after January 1, 1985.

Item	Present Law
4. Moratorium on Mental Impairment Reviews (Section 201 of the House bill and section 5 of the Senate amendment)	Under the Disability Amendments of 1980, all DI beneficiaries with nonpermanent impairments must be reviewed at least once every 3 years to assess their continuing eligibility for benefits. Individuals with permanent impairments may be reviewed less frequently. Presently, there is no distinction in the law between the rate of review for individuals with physical and mental impairments. Under a Secretarial initiative (of June 7, 1983), periodic eligibility reviews have been suspended for certain mental impairment cases involving functional psychotic disorders, pending a revision, with the help of outside mental health experts, of the criteria used for determining disability. Under a subsequent Secretarial action (announced April 13, 1984), all periodic eligibility reviews have been suspended temporarily.

House Bill	Senate Amendment
Requires publication within 9 months of enactment of revised mental impairment criteria in the Listing of Impairments that are designed to realistically evaluate the person's ability to engage in SGA in a competitive workplace environment, taking account of the recommendations of the disability advisory council (section 304). Delays periodic review of mentally impaired individuals until these revisions are made. The delay would apply to cases on which an initial decision had not been made by the date of enactment and to those cases where an initial decision was made prior to the date of enactment and a timely appeal was pending on or after June 7, 1983. Periodic reviews where (1) fraud was involved or (2) the individual was engaging in SGA, would continue to be done. SSA could continue to review medical diary cases and make initial determinations but would subsequently redetermine the cases under the revised criteria. If a new decision were favorable, it would take effect as of the time of the first determination. Mentally impaired persons who received an unfavorable initial or continuing eligibility determination between March 1, 1981 and enactment of the bill and who reapplied for benefits within 12 months of enactment would be deemed to have reapplied at the time of the unfavorable determination for the purpose of establishing a period of disability during the period covered by the prior determination, but not for benefit purposes; benefits would be payable only for the twelve months prior to the date of the new application. The provisions also apply to title XVI. ***Effective date:*** On enactment.	Similar, except requires publication of revisions within 90 days after enactment, and reapplication provision applies to people who received an unfavorable determination since June 7, 1983 rather than March 1, 1981. ***Effective date:*** On enactment.

Item	Present Law
5. Pre-Termination Notice and Right to Personal Appearance (Section 202 of the House bill and section 10 of the Senate amendment)	A person whose initial claim for disability benefits is denied or who is determined after review not to be disabled may request a reconsideration of that decision within 60 days. In the past, reconsideration has been a paper review of the evidentiary record including any new evidence submitted by the claimant, conducted by the State agency. Under a provision of P.L. 97-455, enacted January 12, 1983, disability beneficiaries determined not to be medically eligible for benefits must be given opportunity for a face-to-face evidentiary hearing at reconsideration. Such hearings may be provided by the State agency or by the Secretary. Individuals found ineligible for benefits at reconsideration may request a face-to-face evidentiary hearing before an administrative law judge. The next level of appeal is to SSA's Appeals Council, and finally, to a Federal court.
6. Continuation of Benefits During Appeal (Section 203 of the House bill and section 3 of the Senate amendment)	Disability benefits are payable for the month as of which the beneficiary is determined to be ineligible and for the 2 months succeeding. Benefits do not generally continue during appeal. Under a temporary provision in P.L. 97-455 (as modified by P.L. 98-118), individuals notified of a medical termination decision could elect to have DI benefits and medicare coverage continued during appeal—through the month preceding the month of the ALJ hearing decision. These additional DI benefits are subject to recovery as overpayments if the initial termination decision is upheld (unless they qualify for waiver under the standard provisions for waiver of overpayments). This provision does not apply to terminations made after December 6, 1983. Benefits are last payable under this provision for June 1984 (i.e., the July 1984 benefit check).

House Bill	Senate Amendment
Revises determination process for beneficiaries undergoing periodic review in medical cessation cases, to provide for a face-to-face evidentiary review with State agency (upon request of the beneficiary within 30 days) after a preliminary unfavorable decision by the State. If, after the evidentiary interview (or paper review if the beneficiary requests review without the personal interview), the State agency denies benefits, the beneficiary could appeal to the ALJ and succeeding appeals levels. The reconsideration level would be abolished for these review cases.	No provision.
Requires the Secretary to establish demonstration projects in at least 5 States using this same procedure for initial disability claims, with a report to the Committees on Ways and Means and Finance on the results due no later than April 1, 1985. The provisions also apply to title XVI.	No provision.
No provision.	Requires demonstration projects on providing pretermination face-to-face interviews in disability cessation cases in lieu of face-to-face evidentiary hearings at reconsideration. Report due to Committees on Ways and Means and Finance April 1, 1986.
No provision.	Requires the Secretary to notify individuals upon initiating a periodic eligibility review that such review could result in termination of benefits and that medical evidence may be submitted. The provisions also apply to title XVI.
Effective date: Revised determination process applies to periodic reviews on or after January 1, 1985; demonstration projects to be initiated as soon as practicable after enactment.	***Effective date:*** On enactment. Demonstration projects to be established as soon as practicable after date of enactment.
Permanently extends provision (with technical changes) for continuation of DI and SSI benefits during appeal. Requires the Secretary to report to the Committees on Ways and Means and Finance by July 1, 1986, on the impact of the provision on the OASDI trust funds and on appeals to ALJs.	Extends the provision for continued payment of DI and SSI benefits during appeal to termination decisions made prior to June 1, 1986. (Last month of payments would be for January 1987, i.e., the February 1987 check.)
Effective date: On enactment.	***Effective date:*** On enactment.

Item	Present Law
7. Qualifications of Medical Professionals Evaluating Mental Impairments (Section 204 of the House bill and section 6 of the Senate amendment)	There is no statutory requirement concerning qualifications of persons making disability determinations. Under current policy, the State disability agency team making eligibility decisions must consist of a State agency medical consultant (physician) and a State agency disability examiner, both of whom must sign the disability determination.
8. Standards for Consultative Examinations/ Medical Evidence (Section 205 of the House bill and Section 11 of Senate amendment)	Consultative exams (CE's) are medical exams purchased by the State agency from physicians and other qualified health professionals outside the agency. By regulation, CE's may be sought to secure additional information necessary to make a disability determination or to check conflicting information. Evidence obtained through a CE is considered in conjunction with all other medical and non-medical evidence submitted in connection with a disability claim. There are currently no statutory or regulatory standards requiring CE's in particular cases, or requiring any standard procedures to be followed in the purchase of CE's. The SSI statute includes a cross-reference to this provision. Any changes in title II will therefore also be made for SSI.

House Bill	Senate Amendment
Requires that a qualified psychiatrist or psychologist complete the medical portion of any applicable sequential evaluation and residual functional capacity assessment in cases involving mental impairments before a determination may be made that an individual is not disabled.	Same except modified to require only that every reasonable effort be made to use qualified psychiatrist or psychologist. Also, specifically amends title XVI to make the provision applicable to SSI determinations.
Effective date: On enactment.	***Effective date:*** On enactment.
Requires the Secretary to prescribe regulations which set forth standards for when a CE should be obtained, the type of referral to be made and the procedures for monitoring CE's and the referral process. Permits non-regulatory rules and statements of policy relating to CE's to be issued if they are consistent with the regulations.	No provision.
No provision.	Requires the Secretary to make every reasonable effort to obtain necessary medical evidence from an individual's treating-physician prior to seeking a consultative examination.
No provision.	Also, requires consideration of all evidence in the case record and development of complete medical history over at least the preceding 12-month period for individuals applying for benefits or undergoing review.
Effective date: On enactment.	***Effective date:*** On enactment.

Item	Present Law
9. Administrative Procedure and Uniform Standards (Section 301 of the House bill and section 4 of the Senate amendment)	The guidelines for making social security disability determinations and all other social security eligibility determinations are contained in the Social Security Act, regulations, social security rulings and the POMS (the Program Operating Manual System): *Regulations,* or substantive rules, have the force and effect of law and are therefore binding on all levels of adjudication—state agencies, administrative law judges, SSA's Appeals Council, and the Federal Courts. The Administrative Procedure Act (APA) requirements do not apply to social security programs because of a general exception for benefit programs. On a voluntary basis, however, SSA issues its regulations is accordance with the public notice and comment rulemaking requirements of the APA. *Rulings* consist of interpretative policy statements issued by the Commissioner and other interpretations of law and regulations, selected decisions of the Federal courts, ALJs, the Appeals Council and selected opinions of the General Counsel. Rulings often provide detailed elaboration of the regulations helpful for public understanding. By regulation, the rulings are binding on all levels of administrative adjudication. *The POMS* is a compilation of detailed policy instructions and step-oy-step procedures for the use of State agency and SSA personnel in developing and adjudicating claims. The POMS is not binding on the Administrative Law Judges, Appeals Council or Courts.

House Bill	Senate Amendment
Requires publication under APA public notice and comment rulemaking procedures of all OASDI and SSI regulations on matters relating to benefits. Requires that only those rules issued under Sections b-e of Section 553 of the APA shall be binding at any level of review.	Requires publication of regulations setting forth uniform standards for DI and SSI disability determinations under APA procedures. These rules would be binding at all levels of adjudication.
Effective date: On enactment.	*Effective date:* On enactment.

Item	Present Law
10. Acquiescence or Non-Acquiescence In Court of Appeals Decisions (Section 302 of the House bill and section 7 of the Senate amendment)	Claimants for benefits under the Social Security Act may appeal State agency denials through several levels of administrative appeal. A claimant who wishes to continue to pursue appeal may next turn to the Federal district court with jurisdiction over his or her claim. The district court reviews the record as compiled by the agency to determine whether substantial evidence existed for the agency's decision. The district court's decision may be appealed, by the claimant or the Secretary, to the Circuit Court with jurisdiction, and ultimately to the Supreme Court (which may or may not agree to hear the appeal). Under the Federal judicial system, decisions by a Circuit Court of Appeals constitute binding case law to be followed by all district courts in that circuit. (District courts are not bound by the case law of other circuits and often develop contrary case law on the same issue.) In general, if two circuits rule differently on a particular issue, the Supreme Court will review the issue to settle the dispute, although frequently the Court will decline to review for an extended period of time if the issue is not ripe for disposition, or if it is not of sufficient importance to warrant immediate attention. If a particular policy is found by the Supreme Court to be unconstitutional, or contrary to the statute, that decision is binding on the agency. Most social security cases decided in the Federal courts have little value as precedent for SSA decisions, since most reversals of agency determinations rest on the lack of substantial evidence for the agency's position. However, in some instances, the court's opinion is based on matter of a statutory interpretation. The Social Security Administration abides by the final judgments of Federal courts with respect to the individuals in particular cases. It does not, however, consider itself bound with respect to nonlitigants as far as adopting as agency policy, either in the circuit or nationwide, the interpretation underlying a Circuit Court's decision. If the decision of a Circuit Court is contrary to the Secretary's interpretation of the Social Security Act and regulations, SSA, like some other Federal agencies, issues a ruling stating that it will not adopt the court's decision as agency policy. There are currently 7 such rulings of nonacquiescence by the Social Security Administration.

House Bill	Senate Amendment
Requires that a decision of a Circuit Court of Appeals interpreting title II of the Social Security Act or its regulations in a manner different from prevailing policy be appealed to the Supreme Court or the Secretary must apply the interpretation underlying that decision as agency policy in the circuit. If the Supreme Court denies review, circuit-wide acquiescence with that interpretation would be required until the Supreme Court ruled on the issue. Includes title XVI conforming amendment.	Requires SSA to notify Congress and print in the *Federal Register* (within 90 days after decision date, or on the last date available for appeal, whichever is later) an explanation of the agency's decision to acquiesce or not acquiesce in decisions of the Circuit Courts relating to interpretation of the Social Security Act or of regulations issued under the Act. In cases where the Secretary is acquiescing, the reporting requirement would apply only to significant decisions. States that nothing in the section shall be interpreted as sanctioning any decision of the Secretary not to acquiesce in the decision of a circuit court.
Effective date: On enactment, with respect to all circuit court decisions made on or after the date of enactment, and with respect to circuit court decisions for which the Secretary still has an opportunity to request review by the Supreme Court.	***Effective date:*** Applies to Court decisions rendered after the date of enactment.

Item	Present Law
11. Payment of Costs of Rehabilitation Services (Section 303 of the House bill and section 12 of the Senate amendment)	Presently, States are reimbursed for vocational rehabilitation (VR) services provided to DI and SSI recipients which result in their performance of substantial gainful activity (SGA) for at least 9 months. For such individuals, services are reimbursable for as long as they are in VR and receiving cash benefits. If the individual is reviewed and found to have medically recovered while in VR, cash benefits may continue (under Sections 225(b) and/or 1631(a)(6) of the Social Security Act, work-incentive provisions enacted in 1980). The State agency is reimbursed for these VR services on the same basis as applies to other beneficiaries—only if the beneficiary is returned to SGA for 9 months.
12. Advisory Council on Medical Aspects of Disability (Sections 304 and 307 of the House bill and section 14 of the Senate amendment)	Section 706 of the Social Security Act provides for the appointment of a 13-member quadrennial advisory council on social security. It is responsible for studying all aspects of the OASI, DI, HI and SMI programs. The councils are comprised of members of the public. The next advisory council is scheduled to be appointed in 1985 and to make its final report on December 31, 1986. There are no requirements in the law pertaining to the creation of advisory councils to deal specifically with disability matters.

House Bill	Senate Amendment
Allows reimbursement to State agencies for costs of VR services provided to individuals receiving DI benefits under Section 225(b) who medically recover while in VR, and to those receiving SSI disability who are found ineligible for benefits by reason of medical recovery (whether or not receiving SSI under Section 1631(a)(6)). Reimbursable services would be those provided prior to his or her working at SGA for 9 months, or prior to the month benefit entitlement ends, whichever is earlier, and would not be contingent upon the individual working at SGA for at least 9 months. Also provides for reimbursement in cases where DI or SSI disability recipient does not meet the requirement of successful return to SGA because he refuses without good cause to continue in or cooperate with the VR program.	Same, except does not pay for services to those who fail to cooperate or refuse to continue participation in VR, and does not apply to SSI program.
Effective date: For individual receiving benefits as a result of section 225(b) (or who are no longer entitled to SSI benefits because of medical recovery) for months after the month of enactment.	***Effective date:*** For services rendered to individuals who receive benefits under Section 225(b) for months after the month of enactment.
Requires the Secretary to appoint, within 60 days after enactment, a 10-member advisory council on the medical aspects of disability. This would be in addition to the regular quadrennial council. The council, to be composed of independent medical and vocational experts and the Commissioner of SSA *ex officio,* would provide advice and recommendations to the Secretary on disability policies, standards, and procedures. Any recommendations would be published in the Secretary's annual reports. In addition, Section 307 of the bill requires this advisory council to study alternative approaches to work evaluation for SSI applicants and recipients and the effectiveness of VR services for SSI recipients.	Directs next quadrennial advisory council on social security to study the medical and vocational aspects of disability using *ad hoc* panels of experts where appropriate. The study shall include: (1) alternative approaches to work evaluation for recipients of SSI; (2) the effectiveness of vocational rehabilitation programs for DI and SSI recipients; and (3) the question of using specialists for completing medical and vocational evaluations at the State agency level in the disability determination process.
Effective date: On enactment. Authority for the council expires December 31, 1985.	***Effective date:*** Requires Secretary to appoint members by June 1, 1985.

Item	Present Law
13. Staff Attorneys (Section 305 of the House bill; no comparable Senate provision)	Qualifications for administrative law judge (ALJ) positions are set by the Office of Personnel Management (OPM). To qualify for SSA's GS-15 ALJ position, an applicant must have at least 1 year of qualifying experience at or comparable to the GS-14 grade level in Federal service. Staff attorneys in SSA's Office of Hearings and Appeals (OHA) have the appropriate type of qualifying experience. However, there are no GS-14 positions as OHA staff attorneys; GS-13 is the highest staff attorney position. Prior to a recent decision by OPM, staff attorneys did not have qualifying experience at the necessary grade level. On May 9, 1984, OPM revised this criteria to permit applicants to qualify with 2 years of qualifying experience at the GS-13 level. No GS-14 experience is necessary.
14. SSI Benefits for Persons Working Despite Severe Impairments (Section 306 of the House bill and section 13 of the Senate amendment)	Under the SSI program, an individual who is able to engage in substantial gainful activity (SGA) cannot become eligible for SSI disability payments. Prior to the enactment of a provision in 1980, a disabled SSI recipient generally ceased to be eligible for SSI when his or her earnings exceeded the level which demonstrates SGA—$300 monthly. Under Section 1619(a) of the Social Security Act, enacted in the Disability Amendments of 1980, severely disabled SSI recipients who work and earn more than SGA may receive a special payment and thereby maintain medicaid coverage and social services. The amount of the special payment is equal to the SSI benefit they would have been entitled to receive under the regular SSI program were it not for the SGA eligibility cut-off. Special benefit status is thus terminated when the individual's earnings exceed the amount which would cause the Federal SSI payment to be reduced to zero (i.e., the "break-even" level which is currently $713 per month for an individual with earnings). Under Section 1619(b), medicaid and social services may continue beyond this level, until earnings reach a level where the Secretary finds: (1) that termination of eligibility for these benefits would not seriously inhibit the individual's ability to continue his employment, or (2) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available in the absence of earnings. Section 1619 expired on December 31, 1983. It is being continued administratively under demonstration project authority to those people who were eligible for SSI as of that date.

House Bill	Senate Amendment
Requires the Secretary to establish enough GS-13 and GS-14 attorney advisor positions to enable otherwise qualified staff attorneys to compete for ALJ positions. A 90-day interim progress report and a 180-day final report by the Secretary would be required. *Effective date:* On enactment.	No provision.
Extends Sections 1619 (a) and (b) through June 30, 1986. In addition, requires the Secretaries of HHS and Education to establish training programs for staff personnel in SSA district offices and State VR agencies, and disseminate information to SSI applicants, recipients, and potentially interested public and private organizations. *Effective date:* On enactment, retroactive to January 1, 1984.	Same, except extended through June 30, 1987.

Item	Present Law
15. Frequency of Continuing Eligibility Reviews (No House provision; Section 15 of the Senate amendment)	Under a provision enacted in 1980, all DI beneficiaries, except those with permanent impairments, must generally be reviewed at least once every 3 years to assess their continuing eligibility. Under a provision enacted in 1983 (P.L. 97-455), the Secretary is provided the authority to modify this 3-year review requirement on a state-by-state basis. The appropriate number of cases for review is to be based on the backlog of pending cases, the number of applications for benefits, and staffing levels. On April 13, 1984, Secretary Heckler announced a temporary, nationwide moratorium on periodic eligibility reviews.
16. Monitoring of Representative Payees for Social Security and SSI Beneficiaries (No House provision; section 16 of the Senate amendment)	The Secretary may appoint a representative payee for an individual entitled to social security or SSI benefits when it appears to be in the individual's best interest. Payees must be appointed for individuals receiving SSI who are addicted to drugs or alcohol. A payee convicted of misusing a social security beneficiary's funds is guilty of a felony, punishable by imprisonment for not more than 5 years and/or a fine of not more than $5,000. A payee convicted of misusing an SSI recipient's funds is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year and/or a fine of not more than $1,000. There are no statutory requirements or restrictions on the selection and monitoring of payees.

House Bill	Senate Amendment
No provision.	Requires Secretary to promulgate regulations establishing standards for determining the frequency of continuing eligibility reviews. Final regulations must be issued within 6 months of enactment. Until these regulations are issued, no individual may have more than one periodic review. ***Effective date:*** On enactment.
No provision.	Requires Secretary to: (1) evaluate qualifications of prospective payee either prior to or within 45 days following certification, (2) establish a system of annual accountability monitoring for cases in which payments are made to someone other than a parent or spouse living in the same household as the entitled individual, and (3) report to Congress within 6 months of enactment on implementation of the new system and report annually on number of cases of misused funds and disposition of such cases. The fine for a first offense by a payee convicted of misusing SSI benefits would be increased to not more than $5,000 and, for both programs, a second offense by a payee would be made a felony punishable by imprisonment for not more than 5 years and/or a fine of not more than $25,000. Individuals convicted of a felony under this provision could not be selected as a payee. ***Effective date:*** On enactment.

Item	Present Law
17. Fail-Safe (No House provision; section 17 of the Senate amendment)	The main source of funding for the DI program is that portion of the social security tax allocated by law for disability. At present, the disability portion of the tax is 1 percent (employee and employer combined). It is scheduled to rise to 1.2 percent in the 1990's and to 1.42 percent thereafter. If revenues from the tax exceed amounts needed for benefit payments, the excess is placed in the trust fund reserve. If revenues fall short of the amount needed, the reserve is drawn on to make up the difference. (To make timely benefit payments it is necessary to have at least one month's benefit payments in reserve at the beginning of each month—8 to 9 percent of annual expenditures. Reserves must be sufficient to meet this percentage requirement at the beginning of each month notwithstanding any decline in revenues or increase in expenditures during the year.) To help assure continued benefit payments over the next few years in the event of adverse conditions, the social security legislation enacted in 1983 authorized interfund borrowing for calendar years 1983–1987. In addition, the 1983 legislation required the OASDI Board of Trustees, whenever it determines that trust fund reserves may become less than 20 percent, to immediately submit to Congress a report setting forth its recommendations for statutory adjustments necessary to restore the reserve ratio. This report to the Congress by the Trustees must provide specific information as to the extent to which benefits would have to be reduced, payroll taxes increased, or some combination thereof, in order to restore the trust fund reserve ratio.

House Bill	Senate Amendment
No provision.	Requires the Secretary to adjust disability insurance benefit increases as necessary to prevent the DI trust fund balance from falling below a defined threshold. The Secretary would be required to notify the Congress by July 1 in any year in which the amount of the DI trust fund at the start of the next year is projected to be less than 20 percent of the year's expenditures. If Congress took no action, the Secretary must scale back the next cost-of-living increase for disability insurance beneficiaries as necessary to keep the fund balance from falling below 20 percent. If further necessary to keep the fund from falling below 20 percent, the Secretary would also be required to scale back the increase in the benefit formula used to determine new benefit awards the following year. ***Effective date:*** On enactment.

Item	Present Law
18. Measures to Improve Compliance with Federal Law (No House provision; section 18 of the Senate amendment)	The States are responsible, on a voluntary basis, for determining whether individuals are disabled under the meaning of the Social Security Act. Under the law, States administering the program are required to make disability determinations in accord with Federal law and the standards and guidelines established by the Department of Health and Human Services. All benefit payments and administrative costs of the States making these determinations are financed or reimbursed by the Disability Insurance Trust Fund. The law provides for the Secretary to commence actions to take over the disability determination process if a State fails to follow Federal rules. A series of procedural steps must be complied with before such Federal assumption can be accomplished. The Secretary may not commence making disability determinations earlier than 6 months after: (1) finding, after notice and opportunity for hearing, that a State agency is substantially out of compliance with Federal law; (2) developing all procedures to implement a plan for partial or complete assumption of the disability determinations which grants hiring preference to the State employees; and (3) the Secretary of Labor determines that the State has made fair and equitable arrangements to protect the interests of displaced employees. Prior to the Secretary's announcement in April 1984 of a temporary nationwide moratorium on periodic reviews, several States on their own initiative were failing to conduct eligibility reviews in accordance with Federal law and standards. Eighteen States were operating under court-ordered eligibility criteria or pending court order.

House Bill	Senate Amendment
No provision.	Requires the Secretary to federalize disability determinations in a State within 6 months of finding that the State is not in substantial compliance with Federal law and standards. (Such finding must be made within 16 weeks of the time a State's failure to comply first comes to the attention of the Secretary. During this 16-week period, at the discretion of the Secretary, a hearing could be afforded to the State.) The Secretary would be required, to the extent feasible, to meet the requirements of present law regarding the transfer of functions. Provision expires December 31, 1987. ***Effective date:*** On enactment.

ESTIMATED COSTS OF H.R. 3755 AS PASSED BY THE HOUSE AND SENATE

TABLE 1.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR THE BUDGETARY EFFECT OF H.R. 3755 AS APPROVED BY THE HOUSE

[Fiscal years 1984-89; in millions of dollars]

Budget function	1984	1985	1986	1987	1988	1989	Total 1984-89
Function 550:[1]							
Budget authority	3	10	11	7	8	9	48
Estimated outlays	3	10	11	7	8	9	48
Function 570:							
Budget authority	1	28	28	20	19	9	105
Estimated outlays	7	73	86	83	77	59	385
Function 650:							
Budget authority	−1	−15	−35	−55	−75	−105	−286
Estimated outlays	46	238	268	268	271	195	1,286
Function 600:[1]							
Budget authority	1	7	10	11	13	14	56
Estimated outlays	1	7	10	11	13	14	56
Total costs or savings:							
Budget authority	4	30	14	−17	−35	−73	−77
Estimated outlays	57	328	375	369	369	277	1,775

[1] Funding for entitlements that requires further appropriations action.

TABLE 2.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR THE BUDGETARY EFFECT OF H.R. 3755 AS APPROVED BY THE SENATE

[Fiscal years 1984–89; in millions of dollars]

Budget function	1984	1985	1986	1987	1988	1989	Total 1984–89
Function 550: [1]							
Budget authority	3	10	12	11	5	6	47
Estimated outlays	3	10	12	11	5	6	47
Function 570:							
Budget authority	1	28	19	8	13	6	75
Estimated outlays	7	73	55	42	43	30	250
Function 650:							
Budget authority	−1	−14	−31	−45	−55	−67	−213
Estimated outlays	46	220	225	127	136	121	875
Function 600: [1]							
Budget authority	1	5	8	10	8	11	43
Estimated outlays	1	5	8	10	8	11	43
Total costs or savings:							
Budget authority	4	29	8	−16	−29	−44	−48
Estimated outlays	57	308	300	190	192	168	1,215

[1] Funding for entitlements that requires appropriations action.

TABLE 3.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR ADDITIONAL OUTLAYS RESULTING FROM THE MAJOR PROVISIONS IN H.R. 3755 AS APPROVED BY THE HOUSE

[By fiscal year; in millions of dollars]

	1984	1985	1986	1987	1988	1989	Total 1984–89
Termination of benefits based on medical improvement:							
DI	22	86	123	130	136	133	630
HI and SMI	4	25	35	40	40	40	184
Medicaid	(1)	3	4	4	4	4	19
SSI	1	3	4	4	4	4	19
Multiple impairments:							
DI	(1)	4	7	11	13	15	50
HI and SMI	(1)	(1)	(1)	1	2	2	6
Medicaid	(1)	(1)	1	1	1	1	4
SSI	(1)	1	2	2	3	3	11
Face-to-face evidentiary hearings for reviews:							
DI	0	11	11	8	6	5	41
Continued payment during appeal:							
DI	25	149	134	114	107	31	560
HI and SMI	3	48	50	40	30	10	181
Medical personnel qualifications:							
DI	(1)	7	14	23	25	27	96
HI and SMI	(1)	(1)	1	2	5	7	15
Medicaid	(1)	(1)	1	2	3	4	10
SSI	(1)	2	3	5	6	7	23
Compliance with court orders	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Vocational rehabilitation:							
DI	(1)	2	4	7	8	8	29
HI and SMI	(1)	(1)	(1)	(1)	(1)	(1)	(1)
SSI	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Extension of sections 1619a and 1619b:							
Medicaid	3	7	5	0	0	0	15
SSI	(1)	1	1	0	0	0	2
Total outlays [3]	57	328	375	369	369	277	1,775

[1] Less than $500,000.
[2] The costs of this provision cannot be estimated because they depend on future court decisions.
[3] The details do not add to the totals due to interaction between provisions.

TABLE 4.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR ADDITIONAL OUTLAYS RESULTING FROM THE MAJOR PROVISIONS IN H.R. 3755 AS APPROVED BY THE SENATE

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989	Total 1984–89
Termination of benefits based on medical improvement:							
DI	22	86	123	130	113	90	564
HI and SMI	4	25	35	40	35	25	17
Medicaid	(1)	3	4	4	3	3	17
SSI	1	3	4	4	3	3	18
Multiple impairments:							
DI	(1)	4	7	11	13	15	50
HI and SMI	(1)	(1)	(1)	1	2	2	5
Medicaid	(1)	(1)	1	1	1	1	4
SSI	(1)	1	2	2	3	3	11
Continued payment during appeal:							
DI	25	149	112	−20	0	0	266
HI and SMI	3	48	20	0	0	0	71
Medical personnel qualifications:							
DI	(1)	(1)	(1)	10	10	20	40
HI and SMI	(1)	(1)	(1)	1	1	3	5
Medicaid	(1)	(1)	(1)	1	1	2	4
SSI	(1)	(1)	(1)	2	2	5	9
Compliance with court orders	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Vocational rehabilitation:							
DI	(1)	2	4	7	8	8	29
HI and SMI	(1)	(1)	(1)	(1)	(1)	(1)	(1)
SSI	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Extension of sections 1619a and 1619b:							
Medicaid	3	7	7	6	0	0	0
SSI	(1)	1	2	2	0	0	5
Total outlays [3]	57	308	300	190	192	168	1,215

[1] Less than $500,00.
[2] The costs of this provision connot be estimated because they depend on future court decisions.
[3] The details do not add to the totals due to interaction between provisions.

TABLE 5.—SOCIAL SECURITY ADMINISTRATION OFFICE OF THE ACTUARY ESTIMATES FOR ADDITIONAL OASDI BENEFIT PAYMENTS UNDER H.R. 3755 AS PASSED BY THE HOUSE OF REPRESENTATIVES, BASED ON THE 1984 TRUSTEES REPORT ALTERNATIVE II-B ASSUMPTIONS, FISCAL YEARS 1984–89

[In millions]

Section	Proposal (including bill report requirements)	Fiscal year—						Total, 1984–89
		1984	1985	1986	1987	1988	1989	
101	Medical improvement:							
	Applied to new cases [1]	$30	$380	$460	$500	$540	$600	$2,510
	Applied to prior terminations [2]	440	780	260	210	180	170	2,040
	Subtotal	470	1,160	720	710	720	770	4,550
102	Study concerning evaluation of pain							
103	Guidelines for disability determinations:							
	Multiple impairments	(3)	(3)	10	10	20	20	60
	Noncompetitive work [4]	(3)	(3)	(3)	(3)	10	10	20
201	Moratorium and revised criteria for mental impairment cases.	(5)	(5)	(5)	(5)	(5)	(5)	(5)
202	Face-to-face evidentiary hearing for CDR reviews.		10	20	30	40	40	140
203	Continuation of benefits through ALJ hearing.	60	140	150	160	180	210	900
204	Qualifications of certain medical professionals.	(3)	(3)	10	20	20	20	70
205	Regulatory standards for consultative exams.	(3)	(3)	(3)	(3)	(3)	(3)	(3)
301	Uniform standards for disability determinations.	(3)	(3)	(3)	(3)	(3)	(3)	(3)
302	Compliance with certain court orders	(6)	(6)	(6)	(6)	(6)	(6)	(6)
303	Revision to vocational rehabilitation reimbursement rules.	(3)	(3)	(3)	(3)	(3)	(3)	(3)
304	Advisory Council	(3)	(3)	(3)	(3)	(3)	(3)	(3)
305	Staff attorneys							
(7)	Work evaluation in mental impairment cases.	(3)	(3)	(3)	(3)	(3)	(3)	(3)
	Total before ending State-initiated moratoria on CDR terminations:							
	With sec. 101 applied to new cases only.	70	480	590	660	730	810	3,340
	With sec. 101 applied to new cases and prior terminations.[8]	840	1,290	850	870	910	980	5,740
	Effect of ending State-initiated moratoria on CDR terminations.	−10	−80	(3)				−90
	Total after ending State-initiated moratoria on CDR terminations:							
	With sec. 101 applied to new cases only.	60	400	590	660	730	810	3,250
	With sec. 101 applied to new cases and prior terminations.	830	1,210	850	870	910	980	5,650

[1] Includes effect of applying medical improvement standard to all cases that will be pending a final decision of the Secretary as of the assumed enactment date of Apr. 1, 1984.

[2] Estimates assume that past CDR terminations would be reopened and evaluated under the new medical improvement standard and that reinstated beneficiaries would receive retroactive benefits from the month of termination.

[3] Cost or savings less than $5 million.

[4] Included in bill report only.

[5] No cost is shown for this provision since existing Administration initiatives are expected to accomplish the same results under present law.

[6] This provision has the potential to affect benefit costs substantially, although such effects cannot be estimated since they would depend on unpredictable court cases and the subsequent actions of the court. As an example, if future court cases were to repeat past decisions concerning the evaluation of pain, additional benefits of over $1 billion could occur during 1984-89 as a result of this section.

[7] This item is contained in the committee report only, and is not associated with a particular section of the bill.

[8] Includes $360 million due to continuation of benefits during appeal for past CDR terminations which are reopened and evaluated under the new medical improvement standard but are not reinstated.

Notes: 1. Due to the uncertainty concerning the effects of many of these proposals, actual experience could vary substantially from these estimates.

2. Estimates shown for each section alone (1) are based on the assumption that State-initiated moratoria on CDR terminations would gradually phase out over the next 2-3 years, and (2) exclude the effects of interaction with other proposals. Total costs for bill reflect such interactions.

3. The above estimates do not reflect the effects of the national moratorium on periodic review cases announced on Apr. 13, 1984 by Secretary Heckler.

TABLE 6.—SOCIAL SECURITY ADMINISTRATION OFFICE OF THE ACTUARY ESTIMATES FOR ADDITIONAL OASDI BENEFIT PAYMENTS UNDER H.R. 3755 AS PASSED BY THE SENATE, BASED ON THE 1984 TRUSTEES REPORT ALTERNATIVE II-B ASSUMPTIONS, FISCAL YEARS 1984–89

[In millions]

Section	Proposal	Fiscal year—						Total, 1984–89
		1984	1985	1986	1987	1988	1989	
2	Medical improvement	$150	$440	$400	$410	$400	$250	$2,050
3	Continuation of benefits during appeal (through ALJ level for initial cessations before June 1986).	60	140	110	60	40	40	450
4	Uniform standards for disability determinations.	(1)	(1)	(1)	(1)	(1)	(1)	(1)
5	Moratorium and revised criteria for mental impairment cases.	(2)	(2)	(2)	(2)	(2)	(2)	(2)
6	Qualifications of certain medical professionals.	(1)	(1)	(1)	10	10	20	40
7	Compliance with certain court orders							
8	Multiple impairments		(1)	(1)	10	10	20	40
9	Study on evaluation of pain	(1)	(1)	(1)	(1)	(1)	(1)	(1)
10	Modification of reconsideration pre-review notice.	(1)	(1)	(1)	(1)	(1)	(1)	(1)
11	Case development and medical evidence							
12	Payment of costs of rehabilitation services.	(1)	(1)	(1)	(1)	(1)	(1)	(1)
14	Advisory council							
15	Regulations on frequency of reviews	(1)	(1)	(1)	(1)	(1)	(1)	(1)
16	Monitoring of representative payees	(1)	(1)	(1)	(1)	(1)	(1)	(1)
17	"Fail-safe" reduction of automatic benefit increases for DI beneficiaries.	(3)	(3)	(3)	(3)	(3)	(3)	(3)
18	Measures to improve State compliance with Federal law and standards for the disability determination process.	(4)	(4)	(4)	(4)	(4)	(4)	(4)
	Total for bill [5]	260	470	480	480	450	320	2,460

[1] Cost or savings less than $5 million.

[2] No cost is shown for this provision since existing Administration initiatives are expected to accomplish the same results under present law.

[3] No effect is shown for this provision since, under this set of assumptions, the appropriate DI trust fund ratio would not fall below the 20-percent "trigger level" in this period. See covering memorandum concerning assumed definition of "fail-safe" trust fund ratio.

[4] No cost is shown for this provision since estimates assume that any non-compliance of States would end upon enactment of a medical improvement standard for continuing disability reviews.

[5] Includes $90 million due to continuation of benefits during appeal for past CDR terminations which would be reopened and evaluated under the new medical improvement standard but which would not be reinstated.

Notes: 1. The above estimates do not reflect the effects of the national moratorium on periodic disability reviews announced on April 13, 1984 by Secretary Heckler.

2. Estimates shown for each section alone exclude the effects of interaction with other proposals. Total costs for bill reflect such interactions.

3. Due to the uncertainty concerning the effects of many of these proposals, actual experience could vary substantially from these estimates.

TABLE 7.—SOCIAL SECURITY ADMINISTRATION COST ESTIMATES FOR H.R. 3755 AS PASSED BY THE HOUSE OF REPRESENTATIVES AND THE SENATE

[Total costs for bill in millions]

	Fiscal year—						
	1984	1985	1986	1987	1988	1989	1984–89
House bill—standard applied retroactively:							
OASDI benefit payments	$830	$1,210	$850	$870	$910	$980	$5,650
OASDI administrative cost	33	184	66	62	67	67	479
Medicare	45	95	135	165	195	225	860
Medicaid		5	5	5	10	10	35
SSI	12	21	20	25	29	34	141
Total	920	1,515	1,076	1,127	1,211	1,316	7,165
House bill—Standard applied prospectively:							
OASDI benefit payments	60	400	590	660	730	810	3,250
OASDI administrative cost	12	59	66	62	67	67	333
Medicare	25	45	65	80	95	105	415
Medicaid			5	5	5	5	20
SSI	1	8	13	19	23	29	93
Total	98	512	739	826	920	1,016	4,111
Senate bill:							
OASDI benefit payments	260	460	480	480	460	320	2,460
OASDI administrative cost	26	142	44	33	18	11	274
Medicare	30	50	75	80	90	65	390
Medicaid			5	5	5	5	20
SSI	3	5	6	9	11	13	47
Total	319	657	610	607	584	414	3,191

[1] Includes class action cases in the courts, does not include 3-years sunset.

○